Love Them. Protect Them. Immunize Them.

13th Annual
Arizona Immunization Conference
April 27, 2006
(a one day conference as we transition to a spring date)

Group Registration Form

To be eligible for a group discount of $80.00 each:
Register 3 or more people and send a single check for all registrants.
The conference fee registers participants for the conference.
Registration and check or purchase order must be postmarked on or before April 7th.
If registering after April 7th pay $120.00 per person.
No refunds will be given after April 7th.
Registrants will receive confirmation (including directions) upon receipt.
If you are sending more than 5 people, please duplicate this page before filling in names.
Please contact the Immunization Program Office at (602) 364-3630 if you have any questions.

Organization: _____ **Contact Person:** _____

Street Address: _____

City: _____ **Zip Code:** _____

Phone: _____ **Fax:** _____

REGISTRANTS (please print CLEARLY)

1. **Name:** _____ **Title:** _____
Phone:( ) _____ **E-mail Address:** _____

Please check the most appropriate choice for this person:

☐ Physician-Prim. Care ☐ Nurse ☐ Epidemiologist ☐ Medical Assistant ☐ Lab Tech
☐ Physician-Specialist ☐ Nurse Practitioner ☐ Pharmacist ☐ Physician's Assistant ☐ Other

2. **Name:** _____ **Title:** _____
Phone:( ) _____ **E-mail Address:** _____

Please check the most appropriate choice for this person:

☐ Physician-Prim. Care ☐ Nurse ☐ Epidemiologist ☐ Medical Assistant ☐ Lab Tech
☐ Physician-Specialist ☐ Nurse Practitioner ☐ Pharmacist ☐ Physician's Assistant ☐ Other

Organization: _____ **Contact Person:** _____

3. **Name:** _____ **Title:** _____
Phone:(_____) _____ **E-mail Address:** _____

Please check the most appropriate choice for this person:

☐ Physician-Prim. Care ☐ Nurse ☐ Epidemiologist ☐ Medical Assistant ☐ Lab Tech
☐ Physician-Specialist ☐ Nurse Practitioner ☐ Pharmacist ☐ Physician's Assistant ☐ Other

4. **Name:** _____ **Title:** _____
Phone:(_____) _____ **E-mail Address:** _____

Please check the most appropriate choice for this person:

☐ Physician-Prim. Care ☐ Nurse ☐ Epidemiologist ☐ Medical Assistant ☐ Lab Tech
☐ Physician-Specialist ☐ Nurse Practitioner ☐ Pharmacist ☐ Physician's Assistant ☐ Other

5. **Name:** _____ **Title:** _____
Phone:(_____) _____ **E-mail Address:** _____

Please check the most appropriate choice for this person:

☐ Physician-Prim. Care ☐ Nurse ☐ Epidemiologist ☐ Medical Assistant ☐ Lab Tech
☐ Physician-Specialist ☐ Nurse Practitioner ☐ Pharmacist ☐ Physician's Assistant ☐ Other

Enclosed is a single check for all the registrants listed in the amount of $_____ made payable to TAPI. Registrants will each receive individual confirmation letters including directions and hotel information.

Please make check payable to: TAPI (The Arizona Partnership for Immunization)
Do not make check payable to the Arizona Department of Health Services!
Mail registration form and payment to:
Arizona Immunization Program Office
150 N. 18th Avenue, Suite 120
Phoenix, AZ 85007-3233

Questions? Contact us:
Phone: (602) 364-3646 Fax: (602) 364-3285 E-mail: burkhab@azdhs.gov